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## Healing the Hearts of Healers: A Framework to Cultivate Flourishing and Combat Burnout in Healthcare

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# Healing the Hearts of Healers: A Framework to Cultivate Flourishing and Combat Burnout in Healthcare

## Abstract

Burnout is a leading issue in the United States healthcare system today, afflicting approximately 50% of physicians. It is characterized by emotional depletion and loss of energy, a sense of depersonalization, and a reduced sense of individual accomplishment, resulting in withdrawal from occupation. While often regarded as a personal issue, it is clear that burnout arises from organizational factors and therefore, warrants organizational solutions. However, just as well-being is more than just the absence of ill-being, physician flourishing requires more than just treatment of burnout. The HEAL (Hope, Engagement, Action, Lead) model, the subject matter of this paper, is a framework for instituting positive psychology practices to transform medical culture to address burnout and promote well-being for individuals and the healthcare system. This paper introduces the four pillars of HEALing, including specific interventions that may improve organizational cultures and aid in healing the system and the individual clinicians operating within it. Now more than ever in the era of COVID-19, solutions are needed to address this growing problem. Operating through the lens of positive psychology practices, informed by the unique culture of medical practice, healing our healers may be possible.

## Keywords

Physician burnout, healthcare, organizational change, healing

## Disciplines

Medicine and Health Sciences | Psychology

## **Healing the Hearts of Healers**

A Framework to Cultivate Flourishing and Combat Burnout in Healthcare

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MAPP 800: Capstone Project

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August 1, 2021

### **Abstract**

Burnout is a leading issue in the United States healthcare system today, afflicting approximately 50% of physicians. It is characterized by emotional depletion and loss of energy, a sense of depersonalization, and a reduced sense of individual accomplishment, resulting in withdrawal from occupation. While often regarded as a personal issue, it is clear that burnout arises from organizational factors and therefore, warrants organizational solutions. However, just as well-being is more than just the absence of ill-being, physician flourishing requires more than just treatment of burnout. The HEAL (**H**ope, **E**ngagement, **A**ction, **L**ead) model, the subject matter of this paper, is a framework for instituting positive psychology practices to transform medical culture to address burnout and promote well-being for individuals and the healthcare system. This paper introduces the four pillars of HEALing, including specific interventions that may improve organizational cultures and aid in healing the system and the individual clinicians operating within it. Now more than ever in the era of COVID-19, solutions are needed to address this growing problem. Operating through the lens of positive psychology practices, informed by the unique culture of medical practice, healing our healers may be possible.

*Keywords:* Physician burnout, healthcare, organizational change, healing.

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## Preface

The date was September 26th, 2018. I was standing in one of the exam rooms at Memorial Sloan Kettering Cancer Center, the hospital where I work, returning a missed call from my mom. The second I heard her voice; I knew something was wrong. She started by gently asking if I was free to speak and then told me that her doctors had found a mass on her mammogram. Speechlessly bracing myself against the examination table, I attempted to concoct the "right" thing to say at that moment. Having worked in a cancer hospital for two years at that point, I felt like I usually knew the "right" thing to say, but this time was different. My worlds collided.

Her surgery was on October 11th. When I got to the Josie Robertson surgical floor, I saw my dad sitting by himself, playing Connect Four. I can remember my eyes welling up at the gravity of the situation. We both felt helpless waiting for updates from the surgical team. Finally, after successful surgery, my mom was discharged. My sister and I brought home flowers and gave our mom the tightest side hug, tactfully avoiding her left side.

After 25 consecutive external beam radiation treatments, my incredible mom proudly rang the bell in the radiation suite to mark her treatment completion. The last radiation appointment was a few days before Christmas, and she graciously hosted both Christmas Eve and Christmas day with upwards of thirty guests.

A few months later, she developed a strong cough and was having trouble breathing. She went to her oncologist and, at the suggestion of my aunt, an RN, requested a chest CT. The oncologist said there was only a 1% chance that any complications occurred during her treatments. But my mom is a meditation instructor; she controls her breathing for a living, so she knew something was wrong. Sure enough, she was the 1%. She had a pulmonary embolism, a

life-threatening blood clot in her lung. After another uphill battle with medication and injections over the following months, she fought this battle with the valiance of the first and is healthy today.

We are fortunate that my mom was in tune with her body enough to know that something was wrong. Although her case was uncommon, her situation was not. Her clinical team was an incredible one, but they had seen thousands of breast cancer patients just like my mom and generalized her case against the masses. Unfortunately, most physicians and their clinical teams see so many patients in a single day that it is hard to treat them all with optimal individualized care. In addition, many are suffering from burnout, and it can be a debilitating factor which therefore impacts patient care.

Observing what happened to my mom sparked something within me. I wanted to help; I wanted the patients I worked with to have a more positive experience. To do this as a non-clinician, I believed that it was necessary to address the burnout that many physicians experience. I applied to the Master of Applied Positive Psychology at the University of Pennsylvania with this notion in mind. I had this idea to heal the hearts of those who have devoted their lives to healing.

I was promoted to the management team of my division in March 2020, just as New York City was entering lockdown due to the COVID-19 pandemic. Throughout my time as an essential hospital worker, it became incredibly apparent that a parallel pandemic was upon us. However, unlike COVID-19, the pandemic of burnout among our healthcare workers cannot be fought with a vaccine; it requires thoughtful healing and care. This paper is how I would propose doing so.



**Introduction: Physician Burnout**

*"My candle burns at both ends; / It will not last the night."*

-Edna St. Vincent Millay

This opening line from the poem "First Fig," by Edna St. Vincent Millay, is a stunning depiction of burnout. *Burnout* is a leading issue in the United States healthcare system today (Shanafelt et al., 2012), defined as a specific form of professional tension predominantly among professionals in the human service industry. It is characterized by emotional depletion and loss of energy, a sense of depersonalization (seeing people as objects), and a reduced sense of personal accomplishment, resulting in withdrawal from occupation (Kristensen et al., 2005). In addition, exhaustion from heavy workloads and extended work hours combined with heavy cognitive demands in emotionally charged situations contribute to its occurrence (Lall et al., 2019).

Physician burnout is a significant issue that undermines the well-being of the healthcare system (Stewart et al., 2019) with approximately 50% of practicing physicians experiencing at least one symptom of burnout (Shanafelt et al., 2012; Shanafelt et al., 2015). Burnout is experienced by physicians as well as other health professionals, including nurses, physician assistants, and administrators (Chou et al., 2014). For doctors-in-training, after years of education, tremendous pressures, and for many, heaping educational debt, approximately 28,000 new medical students graduate from allopathic and osteopathic medical universities yearly (IsHak et al., 2009). Many enter residency already burned out from medical school (Dyrbye & Shanafelt, 2016), yet many are hopeful of establishing a career that offers the rare promise of work that is intellectually gratifying, spiritually fulfilling, and economically secure (IsHak et al., 2009). While in residency, however, physicians are subject to low levels of autonomy, intense patient care responsibilities, sleep deprivation (Lockley et al., 2004) and significantly lower

salaries than attending-level physicians; these factors fuel burnout during training that may be challenging to bounce back from (Rodrigues et al., 2018).

Even after training, burnout remains problematic for practicing physicians. A study conducted by Shanafelt et al. (2015) assessed the pervasiveness of workplace strain on physicians and revealed that symptoms of burnout have increased by nearly 10% from just 2011 to 2014, indicating an erosion of work-related well-being in this population. Shanafelt et al. (2015) surveyed 6,880 physicians within the United States, aged 35–60 years, across disciplines, finding that burnout is universal, and not unique or specific to any one particular field or practice of medicine.

West et al., (2018) have observed a correlation between severe burnout and the outcomes of substance abuse, depression, suicidal ideation, decreased intentional self-care routines, and an increased frequency of car accidents. Thus, the impacts of burnout are unfortunate and may be fatal. Additionally, the toll of burnout has adverse consequences extending beyond the individual physician. West et al. (2018) has found that patients may experience increased medical errors, lower quality of care, longer recovery times, and lower satisfaction with the care they receive due to the burnout of their physicians. Additionally, the healthcare system as a whole is impacted by diminished physician efficiency, high attrition rates, increased medical costs due to errors, and decreased access to adequate care for patients (West et al., 2018).

### **Physician Burnout and COVID-19: The Parallel Pandemic**

The novel SARS-CoV-2 coronavirus resulting in the syndrome widely known as COVID-19 was discovered in the Wuhan city of Hubei province of China in December 2019 (Shah et al., 2020). COVID-19 was declared a pandemic by the World Health Organization on March 11, 2020, has since spread to more than 200 countries, and has resulted in 3.5 million

deaths globally to date (World Health Organization Dashboard, 2021). The unprecedented rate of infection and spread has resulted in immense fear and anxiety around the world.

The high infection rate and spread of the virus revealed global unpreparedness, resulting in the inaccessibility of essential personnel (e.g., healthcare workers) as well as medical supplies ranging from oxygen tanks and ventilators to personal protective equipment, all required to keep patients alive and those on the front lines safe (Shah et al., 2020). With the primary focus of policymakers and governments being to minimize infection through prevention and saving lives by developing and investing in treatments and vaccinations, extraordinarily little attention was paid to the critical dilemma of protecting physicians' psychological well-being (Shah et al., 2020).

While physician burnout has been a prominent issue long before COVID-19 was a household name, it became a glaringly obvious concern as the virus surged through our hospital systems. While most Americans (e.g., “non-essential workers”) retreated to their homes, learned the art of Zoom meetings and virtual hangouts, and navigated the intricacies involved in group living, our frontline medical workers left their loved ones and safe spaces behind. While others ran away from the fire, these individuals ran towards it, exposed to the devastation and an unprecedented loss of life that their training could not possibly prepare them for. Indeed, an early study of frontline health care workers in New York City at the pandemic peak revealed that scoring positive for pre-pandemic burnout was the strongest correlate of the subsequent development of symptoms of major depressive disorder, generalized anxiety disorder, or pandemic-related posttraumatic stress disorder (Feingold et al., 2021).

Additionally, it is imperative to note the immense racial and ethnic inequalities exacerbated by this pandemic (Abedi et al., 2021). During this time, specific populations

including black and indigenous communities, were disproportionately impacted, shining a bright light on a long history of systemic racism. A study by Abedi et al.'s (2021) provides substantial evidence of racial, fiscal, and healthcare disparities in the populations most infected by and dying from COVID-19. Researchers concluded that such disparities might result from a lack of personnel for essential services, poverty, pre-existing health disparities, distrust of the medical system, and lack of access to care. On top of the already-existing levels of burnout for physicians, exposure and potentially contributing to this inequity have been purported to further erode physician well-being (Abedi et al., 2021) and may contribute to moral injury, an even more profound emotional wound (Čartolovni et al., 2021). Moral injury, as described by Dean et al., (2019) may be defined as the psychological reckoning of being incapable of delivering a treatment that patients need and deserve outside of the physician's control. Further, moral injury identifies that the source of distress is a broken system, not a broken individual (Dean et al., 2019). However, this experience can feel incredibly painful for physicians.

With more physicians reporting increasing levels of distress and new magnifying glass on what has been termed a “parallel pandemic” (Dzau et al., 2020) there is a heightened demand for initiatives geared toward both healing and prevention. By systematically applying positive psychology principles to physicians and healthcare workers, such healing may be possible.

### **Positive Psychology: A Brief Introduction**

In 1998, former American Psychological Association president Dr. Martin Seligman boldly called for reimagining the priorities of the psychology field. Seligman suggested that instead of solely relying on the well-respected handbook of mental disorders, the *Diagnostic and Statistical Manual (DSM)*, he suggested the creation of a handbook of the sanities of the human experience, consisting of terms such as optimism, honesty, perseverance, compassion, and

meaning (Peterson & Seligman, 2004). Seligman explained that until that point, psychology was consumed with treating weaknesses at the expense of exploring strengths.

Seligman, with the help of many other leaders within psychology, founded a new field, positive psychology, which examines the aspects of life that increase well-being and allow individuals to flourish (Seligman, 2011). Today, positive psychology is the scientific study of what makes life worth living (Gable & Haidt, 2005). Seligman and Csikszentmihalyi (2014) described positive psychology based on a combination of positive experiences, positive traits within oneself, and positive organizations that foster well-being and impact positive change. Adler and Seligman (2016) recognized that well-being requires both eudaemonic well-being (functioning well) and hedonic well-being (feeling good). Thus, although the word "positive" is within the name, it is more than the study of happiness or elation; it is the science of what makes life good, what drives people to look forward to what is ahead, and it is increasingly focused on engaging and uplifting those who are struggling.

“Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (Constitution of the World Health Organization, 1946). Much like health described here, positive psychology is inherently not about the absence of bad; it is about the presence of good. Positive psychology research has demonstrated that physical, mental, and social well-being are not plainly important elements for widespread health, but they are also all deeply interconnected (Park et al., 2016). Over the last several years, data has shown that a happy, connected, and fulfilling life is not just a result of good health, it is also a result of positive psychological health assets (e.g., hope, optimism, strong relationships, meaning) (Park et al., 2016). Park et al. (2016, p. 6) expressed that, “the quality-of-life matters in addition to

quantity of life.” Thus, assisting people in developing positive psychological and community resources has capacity to aid individuals in living to more meaningful, and happier lives.

In addition to scoping the field and setting it in motion, Seligman (2018) created a framework—PERMA—of the elements that he felt, and the science revealed, were the essential aspects of well-being. PERMA, which stands for **P**ositive Emotions, **E**ngagement, **R**elationships, **M**eaning, and **A**ccomplishment, was Seligman’s effort to influence psychology to shift the focus from solely mental illness to studying the discrete elements that comprise well-being (Seligman, 2018).

### **Positive Psychology and Physician Burnout: The Steps Toward HEALing**

In the last decade, there has been a convergence of positive psychology and the field of medicine. In one such example, Feingold (2016), a graduate of the MAPP program at the University of Pennsylvania and a physician, sought to produce a complementary framework that would help her both address the well-being of her colleagues and clinicians and increase flourishing for patients as well. In 2016, she authored a MAPP capstone on REVAMP (**R**elationships, **E**ngagement, **V**itality, **A**ccomplishment, **M**eaning and **P**ositive Emotions) (Feingold, 2016), which iterated on Seligman's PERMA and spun it in the direction of physician well-being and flourishing. Today, as the ingredients of well-being are more or less understood and accepted, and the rationale for well-being interventions are more clear with the recognition that distinct approaches are needed for reducing distress and mental illness versus promoting well-being and optimal engagement in work. What remains is a need for systematic frameworks for employing such positive psychology concepts into the medical landscape to achieve both.

As in most successful relay races, the baton pass is thoughtful and calculated. From the discovery of Seligman's PERMA in 1998 to Feingold's REVAMP in 2016, the baton is now

passed to an era of HEALing. The rest of this paper is devoted to the HEAL model, what we conceive of as the path forward for implementing positive psychology for physicians.

### **The HEAL Model**

*“Each of us has a unique part to play in the healing of the world.”*

-Marianne Williamson (2012), *“The Law of Divine Compensation: Mastering the Metaphysics of Abundance”*

The HEAL (**H**ope, **E**ngagement, **A**ction, **L**ead) model, the subject matter of the rest of this paper, is a framework for instituting positive psychology practices for culture change in medicine to address burnout and promote individual and systemic well-being. It may be helpful to think about this model and its core elements through the metaphor of a tree. Trees have a strong base, reach great heights, offer shade and security, and are often symbols of strength. We would like you to approach the HEAL model with this visualization in mind (Appendix A).

**Hope** is the trunk, it is the base of the tree, without a strong base, the tree would be unable to survive and grow. Then we have **engagement**, which symbolizes the roots bringing nutrients directly from the soil; it is the grounding component. The third step in this process is **action**, represented by the water and sunlight that nourishes the tree; it aids in the production of blossoming greenery and sturdy branches, and without water or sunlight, the tree cannot flourish. Finally, we have **lead**, symbolized by opportunities for new growth, the oxygen that the tree provides for the environment, the shade it offers. Putting it all together, the HEAL model evokes the image of a flourishing, strong, and healthy tree that recognizes its strength and provides shade and other services to others. With that said, we introduce the HEAL model.

### **Hope**

*"You are meant to do more than survive; you are meant to thrive."*

-Dan Tomasulo (2020), *"Learned Hopefulness."*

Hope is a critical facet of human life that implies that there is the possibility of a better future (Snyder, 2002). Snyder (2002) explains that hope surfaces when things are dire and difficult and propels individuals forward. Even in difficult times, if individuals can see the faint glimmer of something better, then hope may turn them toward that something better.

Thinking back to the oak tree visualization, *hope* is the trunk or the base. Without a strong trunk as its base, a tree would not have the ability to grow. Similarly, the HEAL model could not exist without hope. Thus, hopefulness is the single most important beginning to any framework for change; it asserts that goodness is obtainable and lies ahead.

### **Hopefulness vs. Helplessness**

To understand the importance of hopefulness, it is imperative to understand the opposite—helplessness. "Learned helplessness," which was discovered decades ago, is a term that describes specific behavior displayed by a subject after enduring repetitive unpleasant stimuli beyond their control (Maier & Seligman, 2016). Initially, learned helplessness was thought to be impacted by a subject's acknowledgment and acceptance of their lack of power in a situation, often resulting in suspending any efforts to escape or avoid the unpleasant stimulus (Maier & Seligman, 2016). Maier and Seligman (2016) explained that displaying such behavior meant that the subject was said to have developed "passivity," known as learned helplessness. This passivity occurs due to an evolutionary response when something terrible or prolonged happens (Tomasulo, 2020). Imagine how learned helplessness may impact physicians exposed to chronic work-related stress. Now, what does this mean for hope?



There is little-known literature underscoring the importance of hopefulness in physicians. Most physicians understand the need for patients and their support systems to be hopeful but may not recognize the need for hope themselves. The pressure to remain hopeful on behalf of a patient and their support systems while the prognosis is dismal may be both challenging and draining, especially for trainees who are just learning to navigate this fine line and classically report a lack of autonomy. This type of pressure contributes to the textbook definition of burnout: emotional depletion, loss of energy, and reduced sense of personal efficacy (Sigsbee & Bernat, 2014; Kristensen et al., 2005) and its subsequent withdrawal from medical practice and the previously mentioned detrimental, even life-threatening consequences.

### **Cultivating Hope**

In his book, *"Man's Search for Meaning,"* author Viktor Frankl expressed, "it is a peculiarity of man that he can only live by looking to the future." Frankl cautioned that "the sudden loss of hope and courage can have a deadly effect" and remarked that "[he] who had lost his faith in the future—his future—was doomed" (Frankl, 2006). This stark reality holds true for the burned-out physician who loses hope; the future seems grim. Thus, cultivating realistic hopefulness among physicians is a critical step for protecting the well-being of this population and laying the groundwork and buy-in for other well-being interventions. So, how does one cultivate hopefulness?

There are distinct methods that influence the ability to cultivate hope. Worthen and Isakson (2010) state that goal setting, incentive and motivation systems, self-regulation abilities, attachment and bonding activities, and decision-making facilities may contribute to feeling and producing hopefulness. Therefore, physical well-being and effective self-care influence the ability to hope (Worthen & Isakson, 2010). Ultimately, building a genuine foundation for

hopefulness within the medical profession, within undergraduate medical education, residency training, and continuing education for those in practice may be essential for bolstering the sustainable well-being of those in healthcare.

Hope is when we believe our actions matter, but it is also accepting the limitations of our actions. For instance, some 12-step programs utilize the Serenity Prayer (Appendix B) as a mechanism to remind individuals that some things are outside one's control. Even if the individual is not religious, recognizing that many things are outside one's control can bring a sense of peace. The peer-support model of most 12-step programs is something to consider for physicians as a norm within clinical practice. Such support groups might help to alleviate work-related burnout and foster community, and sponsorships from more senior or previously burned-out physicians such as recent retirees may make those who are currently struggling, more hopeful.

Hope provides the individual with the capability to create specific inspiration and devotion to follow the pathways to life satisfaction (Passmore et al., 2020). Passmore et al., (2020) note that hope combats the symptoms of secondary traumatic stress (STS) which can resemble a more advanced form of burnout. Further, research findings show that hope has a positive impact on physical and emotional well-being, and hopeful individuals are less reactive to stressful situations (Passmore et al., 2020).

Thus, hope is the critical foundation for implementing well-being initiatives for physicians. Ultimately, until we build a foundation of hope within physicians and provide outlets for physicians to practice shaping their work environments and cultures, tending to the well-being of physicians will likely not succeed. Building realistic hopefulness can further open the

door for further positive psychology interventions, and it is thus the first pillar in the HEALing process.

### **Suggested Interventions:**

In order to cultivate *hopefulness* for physicians, we suggest the following techniques that can be undertaken by an individual physician or in guided training sessions:

- Host Story-Share events
  - Intervention: During service meetings or ground rounds, set aside time for individuals to share a meaningful story of their choice. These stories could range from a significant patient interaction to, to overcoming personal failure, to challenging a norm withing practice, or any story that displays vulnerability and conveys hope for listeners. *This activity can be done in a group setting or one-on-one.*
  - Anticipated outcome: Sometimes it is best for the individual to step away from their own familiar narrative and listen to someone else's in order to get out their own head to discover that they are not alone and imagine a better future. Research on cancer patients performed by Chelf et al. (2000) revealed that storytelling produces therapeutic effects including building hope in both story deliverers and story receivers. These types of events are incredibly popular in medical settings as a means for fostering community. In an effort to cultivate closeness, physicians at the University of Colorado School of Medicine piloted storytelling events which consisted of an hour-long program that uses storytelling as a means to decompress and debrief emotionally difficult cases they have experienced (Turner, 2019).

Clinical teams at the University of Colorado found this intervention phenomenally successful and curated a higher sense of well-being amongst the team.

- Write Letter to Future Self

- Intervention: Using Futureme.org, urge physicians to write to their future selves.

They might write about the research they hope to do, their personal accomplishments outside the hospital, what aspects of themselves are non-negotiable to maintain and nurture during medical training and practice, etc. Most effectively, doctors can be “prescribed” this intervention at regular intervals through practice and given the time to write and read these letters, supported by their supervisors.

- Anticipated outcome: These letters will aim to hear the hopefulness of own past self and aid the physicians in looking forward to brighter futures for themselves.

- Create Burnout Support groups

- Intervention: Cultivate a *space* for which physicians can speak of their experience, symptoms, and effects of burnout. This space may be physical or virtual and should be used as a place to discuss challenges and support others experiencing burnout and moral distress. We suggest having facilitators who are trained in positive psychology principles to assist with guiding with the conversations, so that they do not turn into solely venting sessions. This can be a place to learn constructive, evidence-based positive psychology tools for addressing problems.

- Anticipated Outcome: We believe that providing a space in which physicians can unapologetically express their experiences with burnout without the worry of

repercussions, as well as learn concrete coping mechanisms, will be profoundly help with the healing process. Further, research by Davison et al., (2000) found that reciprocal support groups, requiring little or no cost to members, have a powerful effect on mental and physical health.

### **Engagement**

*“Engaged employees are psychological “owners,” drive performance, innovation and move the organization forward.”*

– Gallup Report 2017

The second element of HEAL is *engagement*. Engagement can be defined in various ways; within the REVAMP model, engagement is defined as absorption in the present moment and is characterized by flow states, mindfulness practice, and using one's unique strengths in everyday life and the workplace (Feingold, 2016). Within HEAL, the definition of engagement can be described as the extent to which physicians feel passionate about their work, are committed to their organizations, and are purposeful with their actions. It is the roots for the tree, it is the method in which nutrients nourish the tree and aid in its flourishing. Indeed, this type of engagement, synergistic with a hopeful foundation, may significantly contribute to burnout reduction and enhance the well-being of physicians, with potential positive downstream impacts for patients.

There are several paths to engagement that may be cultivated in educational, training, and workplace settings for physicians across all stages of development and include engaging with the self, engaging with others, and engaging with the workplace.

### **Engaging with the Self- Mindfulness**

Mindfulness is a practice in which an individual maintains recognition in the present by focusing one's awareness on recognizing and acknowledging one's emotions, beliefs, and physical sensations moment-to-moment (Ludwig & Kabat-Zinn, 2008). The objective of

Mindfulness practice is to sustain awareness and detach oneself from thoughts or emotions, thus fostering a greater sense of emotional balance and well-being (Ludwig, 2008). In addition, Ludwig (2008) explains that an objective of mindfulness practice is to take more significant accountability for one's decisions and actions. Further, formally introducing a mindfulness practice to physicians and those in training as part of medical education may help cultivate individuals' internal resources when facing stressful situations that arise on the job.

Mindfulness-based interventions (MBIs) are designed to aid an individuals' purposeful self-regulation of thought from moment to moment. They promote a deliberate focus of awareness to calm the mind and body (Burton et al., 2016). MBIs, whether offered individually or in a group setting, may offer various benefits to physicians operating in stressful circumstances. MBIs geared toward group cohesion and stress reduction would be most beneficial for physicians across the board.

In a review by Kriakous et al. (2021), it was found that mindfulness-based stress reduction (MBSR) is a practical intervention that can help enhance medical professionals' psychological functioning. Furthermore, Kriakous et al. (2021) found that MBSR programs are most effective when woven into medical professionals' daily schedules instead of traditional programs are conducted outside of work. The review also emphasized the value of MBSR programs in nudging the medical professionals to participate in daily mindfulness practice to amplify the long-term outcomes of the MBSR program. Reported long-term outcomes include decreased rates of depression and emotional exhaustion and increased levels of personal accomplishment amongst medical professionals (Kriakous et al., 2021). In other words, engaging in mindfulness may be a powerful antidote to burnout.

**Engaging with Others- High-quality Connections**

Human connections are vital for the success of teams and organizations. Whether they form long-term relationships or brief positive encounters, all connections may leave lasting impacts (Dutton & Heaphy, 2003). According to Dutton and Heaphy (2003), organizations rely on individuals to interact and form connections to accomplish the work of the organization. Specifically, "high-quality connections" (HQCs) are often the most beneficial for the individual as well as the organization.

High-quality connections are distinguished from other types of connection by the presence of mutual positive respect, trust, and active effort by all parties. While a part of a high-quality connection, individuals report experiencing feelings of openness, competency, and vitality; they feel more "alive" (Dutton & Heaphy, 2003). HQCs may take place between individuals who are intimately connected or not. Thus, HQCs can be pursued in short-term dyadic relationships, for example, between a physician and a nurse who might not know each other well and work together in only limited settings. In addition to these short-term, workplace interactions, Gable and Gosnell (2011) argue that intimate and cherished relationships are uniquely and strongly linked to increased health and well-being. Furthermore, social isolation and loneliness are conversely associated with a considerable increase in all-cause mortality (Gable & Gosnell, 2011).

According to Gable & Gosnell (2011), close relationship partners are often active participants in each other's advancement and goal quest, contributing to what is known as the "Michelangelo phenomenon." The Michelangelo phenomenon states that there is consistent evidence that within a relationship, each individual encourages the other by provoking vital characteristics of the other's values, therefore shifting the other closer to their ideal self with

enhanced well-being as a result (Rusbult et al., 2009). In other words, partners help one another manifest their “ideal selves.” While all support is considered beneficial, there are different types that Gable and Gosnell (2011) highlight. Structural support refers to the social connectedness web that an individual is a part of; enacted or received support refers to the tangible asset that is actually given, and perceived support, the perception that others will offer (or have offered) practical help during times of need, has been shown to be the most beneficial for relationship quality and well-being.

Substantial and poignant support from others during times of stress and discomfort has long been thought to be a significant pathway through which social ties are linked to health and well-being (Gable & Gosnell, 2011). Additionally, The Joint Commission (2008) notes that the safety and excellence of patient care within healthcare systems depend largely upon the environment and atmosphere where care is offered. Therefore, it is important to look at the relationships between physicians, the relationships between physicians and patients, and the relationships between physicians and non-physicians, such as other members of the care team and non-physician leaders as well.

As such, optimal engagement with other people can and should involve high-quality dyadic interactions in the workplace as well as embracing close, interpersonal relationships where the presence of perceived support is available. Deliberately attending to each of these relationship units within healthcare cultures would likely lead to increased employee and patient satisfaction, as well as the quality of patient care.

### **Engaging with the Workplace- Mattering**

Mattering is fundamentally the ideal state in which an individual feels as though they are valued and are adding value (Prilleltensky, 2019). According to Prilleltensky (2014), mattering



may be regarded as a sense of belonging and can be broken down into two important moments: recognition and impact. Recognition refers to the signs an individual gets from their community or workplace that their existence matters, that what they say holds weight, and their very presence at the table matters to their family, place of work, and in the larger community (Prilleltensky, 2014). Further, impact refers to one's sense of agency; the decisions one makes have an impression and bearing on the world and people around them. Prilleltensky (2014) notes that both recognition and impact occur on a continuum; for example, recognition has a high sense of privilege or opportunity at one end and invisibility at the other—it is not simply absent or present. No matter how confident, successful, or intelligent a person is, all humans crave the feeling of mattering and being valued (Prilleltensky, 2019).

Elliott et al. (2004) posits that people feel like they matter when others value them, invest in them, or look to them for resources. Therefore, an organization that does not focus on its employees' mattering is the beginning of a perilous downward spiral. Mattering must be cultivated by the leaders of an organization (I will elaborate more on this later in the *lead* section).

### **Suggested Interventions:**

In order to cultivate *engagement* for physicians, we suggest the following techniques that can be undertaken by an individual physician or in guided training sessions:

- Mindfulness Rounds

- Intervention: The environment within a healthcare organization is often overwhelming and fast-paced. We suggest hiring a meditation instructor to train the physicians on meditation and arm them with the tools so they can be utilized on command. We suggest placing mindfulness “nudges” throughout the

organization to remind the physician to remain mindful. For example- having a sign that says “feet on the floor” inside the elevator may help with grounding.

- Anticipated Outcome: By encouraging “mindfulness rounds” this will inspire physicians to take a moment of pause at the beginning of their shift, ground themselves and begin their shift on a positive note.
- Encourage Moving from “Small Talk” to “Big Talk”
  - Intervention: During departmental meetings encourage physicians to partake in sharing things that help members of the team connect. To get this started, maybe ask the team a question like “what is one thing you are excited about right now?” (See Appendix C for more questions like these) or ask is anyone has encountered a psychologically sacred moment since the last time the team met together.
    - Psychologically sacred moments refer to brief periods in which individuals encounter moments of greatness, limitlessness, or interconnectedness and need not have a religious connotation (Goldstein, 2007). These moments could range from a breakthrough in a patient’s care to helping their child ride a bike for the first time.
  - Anticipated Outcome: Through the sharing of psychologically sacred moments and engaging in “big” rather than small talk, we anticipate physicians to feel a level of closeness and relatedness to their colleagues.
- Mattering Facilitation
  - Intervention: We suggest scheduling regular time for face-to-face conversation between leadership, physicians, and non-physician leadership in an effort to

bridge the gap and improve a sense of understanding and mutual respect within the organization. Additionally, it is imperative for non-physician leadership to understand and aid with instilling consistent values across the institutions.

- Anticipated Outcome: One of the many goals of a mattering intervention is to bridge the gap between leaders and the rest of the system.

### **Action**

*“Action is the foundational key to all success.”*

-Pablo Picasso

Within the HEAL model, *action* is the third critical pillar. Action can be defined as the steps needed to catalyze systemic change in an iterative process that can be continually revisited, streamlined, and promoted within a healthcare setting. It is the water and sunlight that aids with the flourishing and growth of the tree. It is an imperative component of this model because explicit actionable strategies are required to move the pendulum forward and ignite the systemic change toward embracing healing for healthcare workers. This section discusses two concepts from positive psychology interventions, character strength interventions and Appreciative Inquiry (AI), that are useful in aiding the culture change and may be readily incorporated into health care settings. We also discuss the importance of taking specific *action* to support social injustice for patients and communities as a meaningful path toward combatting burnout and moral distress for physicians.

### **Character Strengths**

Character strengths are positive qualities that are rewarding, unique, and are valued universally across history, time, philosophy, culture, religion, education, and belief systems (Niemiec, 2018). These strengths are fundamental to an individual’s identity and add to the collective good of a community. In the last several years, researchers have found 24 different character strengths categorized under six virtues (wisdom, courage, humanity, justice,

temperance, and transcendence) that all human beings, in the absence of severe psychopathology, possess. These strengths have been inventoried in a book, *Character Strengths and Virtues* (Peterson & Seligman, 2004) which is analogous to the aforementioned *Diagnostic and Statistical Manual*; however, instead of highlighting everything that can go wrong with the human psyche, these strengths reflect what goes right. Using one's top character strengths has been shown to be associated with greater happiness, subjective well-being, achievement, and improved physical health (Niemic, 2018). Specifically, the research and practice of using character strengths at work can increase employee well-being (Höge et al., 2019). Implementing character strengths interventions within the workplace are an actionable method to cultivate systemic change.

Utilizing character strength interventions can benefit those in every area of healthcare. This requires orienting training physicians to the 24 strengths, spotting their own top strengths and the strengths of others, incorporating discussions of strengths into career and specialty decisions, and seeking to understand the strengths of patients (and even incorporating strengths into patient case conceptualizations. Concerning burnout, the application and use of character strengths interventions may positively influence well-being, mental health, and physical health, all of which impact the likelihood of experiencing burnout. One study performed by Hausler and et al., (2017) found that when first-year medical students capitalized on opportunities to apply their character strengths at work (using the *Applicability of Character Strengths Rating Scales*), their well-being and mental health improved, through perhaps due to the age and physical robustness of this population, their physical health was not significantly impacted. Further, Hausler et al. (2017) found that the more the medical students and physicians reported using their character strengths at work, the higher the well-being and better mental health they had.

## **Appreciative Inquiry**

Appreciative Inquiry (AI) is a method of organizational change that looks at what an organization values and does well to create a clear concept and strategy for the future (Cooperrider & Sekerka, 2003). Cooperrider and Srivasta (1987) note that a core principle of AI is the assumption that a meaningful, encouraging conversation is the groundwork upon which a collective positive vision of the future can be constructed, and attempts to fix systems by focusing only on eliminating the problems will get stuck in those problems. In contrast, AI offers those who use it to create change in a positive and procreative way (Cooperrider et al., 2008). This method aims to uncover possibilities for progress and transformation that must be derived from all community contributions. A community's plans are most robust when the collective strengths of its members create them, and a shared vision of a promising future inspires members to draw upon their strengths to create a more positive and generative future (Stavros & Torres, 2018).

Appreciative Inquiry is based on the belief that "we live in worlds our conversations create" (Stavros & Torres, 2018). Because AI was founded at the Cleveland Clinic, it has uses in most areas of healthcare. The authors of *Appreciative Inquiry in Healthcare* illustrate several domains that the method has been utilized to increase dialogue and cooperation throughout the University of Virginia's healthcare system, helping people with different perspectives to work together to create a unified vision of the future (May et al., 2011).

AI can be compared to utilizing character strengths at the systems level. We believe that positive change happens based on capitalizing on what institutions already do well, rather than by focusing on what they are deficient in. In essence, that would mean examining medical cultures that have the highest rates of well-being and dissecting what the features are of these

systems, services, units, or floors, and then begin to emulate them. As medicine is often hyper-focused on problems or getting rid of disease (eliminating badness), a focus on both character strengths for individuals and applying AI within systems will produce a real paradigm shift (promoting existing goodness). This shift will ideally recapitulate the positive cultural changes that are necessary for healing our healers.

Healing a broken system is no easy task. Once identified, the changes needed to enhance the system may take years to accomplish. However, this shift may be catalyzed through devoted personnel to lead such culture change; this will be the topic of the next section. Further, although Appreciative Inquiry and Character Strengths interventions are respected and valuable techniques for organizational change, positive change will also require addressing the injustices that exist within the medical system. Despite the modest progress in the overall physical health of the American population, the health of America's racial and ethnic minorities is disproportionately lagging (Smedley et al., 2003). For example, the health conditions of African Americans—a racial-ethnic group encumbered with deep-rooted and relentless historically-based health inequalities—have been portrayed as stagnant or deteriorating for the last few decades (Smedley et al., 2003). Further, on the coattails of COVID-19, the African American community saw exponentially more losses of human life (Kim & Bostwick, 2020).

Many physicians enter into medicine because of a strong orientation toward service, yet the healthcare system's realities often stand in contrast to this orientation and proliferate inequity, in ways that are ostensibly outside of physician's control. For example, many health care systems are segregated by insurance statuses (which closely mirror racial lines, e.g., patients of color disproportionately lacking private insurance options and, therefore, seen by less experienced clinicians such as trainees instead of attending-level doctors). Further, black women are

significantly more likely than white women to die during childbirth. These disparities have been purported to contribute to burnout and the previously mentioned moral injury, as physicians reckon with their limitations in treating all patients equitably in the context of an often-unjust system (Kopacz et al., 2016). Ultimately, this is an issue that must be addressed and prioritized in the quest to address physician burnout and promote well-being; these concepts do not occur in a vacuum. We hope that through community action and organizing, the two may be fostered mutually. Physician Leo Eisenstein (2018) posits that there are two benefits of collective advocacy for physicians; the first is obvious, it benefits the patient. The second is that tackling the detrimental social factors of the healthcare system can boost physicians' morale and therefore indirectly address their well-being. Therefore, uniting toward community action results in a mutual benefit for the patients and physicians.

Through the attention to character strengths and Appreciative Inquiry, we hope to create a positive shift in the culture of healthcare institutions while promoting well-being systemically. Additionally, it is believed that addressing the social injustices within healthcare will aid in physician's engagement with the community and therefore build meaning and greater workplace satisfaction among physicians by enhancing the quality of patient care.

### **Suggested Interventions:**

In order to promote *action* in physicians, we suggest the following techniques that can be undertaken by a healthcare system:

- Patient Character Strengths Initiative:
  - Intervention: Encourage physicians to identify character strengths within their patients to incorporate into treatment plans and assess how best to communicate and deliver information over the course of their care. This can be readily done

through the addition of character strength templates through the electronic medical record (EMR) in the standard medical notes that physicians regularly complete.

- Anticipated Outcome: We expect that this intervention will result in a more holistic understanding of patients, examining not just their deficits or disease but also their best qualities. Additionally, we believe it can transform medical culture and aid in patient satisfaction.
- Facilitate Advocacy Events
  - Intervention: Spare time is not something a physician has excess of. Therefore, we encourage leaders within the healthcare to facilitate advocacy events within working hours in which physicians can use this time to call their local senators or representatives to advocate for the issues most relevant to their patient populations.
  - Anticipated Outcome: Physicians have an incredible amount of education and often a substantial influence on their communities. We would like to empower physicians to leverage their authority and power to help fix the broken system.
- Plan for an Appreciative Inquiry Summit
  - Intervention: The summit will allow for individuals to voice their opinions on current barriers to well-being at each level of the system and gather thoughts on approaches that can be useful for addressing the issue.
  - Anticipated Outcome: The purpose of an AI summit is to bring together individuals from all levels of the healthcare system to envision a pathway toward a culture focused on well-being. This collaborative effort will aid in bridging the



hierarchical gap as well as facilitate meaningful conversations geared toward change.

### **Lead**

*“A successful leader helps individuals be their best, while stressing the importance for the entire group to achieve a goal vs achieving individual goals.”*

-Donald Sutton

The fourth (and final) pillar of the HEAL model is *Lead. Leadership* is often defined as the art of motivating a group of individuals to take steps toward achieving a collective goal.

When done with intention and purpose, influential leaders can be the catalysts for effective and meaningful change. Just as a large oak tree releases substantial oxygen into the atmosphere and offers shade to those who need it, a good leader is focused not only on their success but also on their team's success. *Lead* is a necessary part of the HEAL model because it facilitates the change and encourages others to get on board. This section will dissect the facets of leadership essential for the HEAL model to be effectively implemented.

### **The Need for Change**

The first step in any process that requires change is acknowledging the problem and cultivating a clear vision of an optimal future. Therefore, the issue at hand is asking physicians to provide practical and thoughtful patient care while they are becoming progressively more burned out (Montgomery, 2016), and a vision is a more accepting and understanding future within healthcare in which burnout is addressed as part of the system, and not simply an individual's problem. Despite the rising frequency of physician burnout and patient care-related concerns, burnout is still predominantly regarded as a personal issue (Montgomery, 2016). According to Montgomery (2016), the factors related to physician burnout are more organizational than they are individual, deep-rooted in matters linked to the organizational environment and culture. Thus, it must be up to the organizational leaders to facilitate organizational change.

As stated above, the first step in any growth process is identifying the problem at hand; if everyone within the organization were to pretend the issue of burnout did not exist, then there would be mass silent suffering; much of this does still exist today. Therefore, we ask for leaders to demonstrate that the organization *cares*. This is more than gifting every physician with a yoga mat with the hospital's logo on it. Shanafelt and Noseworthy (2017) discuss the importance of appreciation and vulnerability of hospital leaders for their hospital staff, and the power that is talking about and normalizing burnout, and of course, finding solutions. Shanafelt and Noseworthy (2017) suggest town halls or video interviews on a large scale and face-to-face meetings on a smaller scale as a method of acknowledging the issue. During these conversations, the case of burnout must be regarded as equally important to discussions concerning finances, patient satisfaction, or quality/safety. The leaders must buy into the topic, believe and acknowledge the severity of the issue, and want to change; indeed, organizational change must first come from the top.

Additionally, leaders must be vulnerable themselves, sharing in ways that were previously viewed as fragile. They must model openness and vulnerability so that those who follow are met with open arms, not turned against or touted as 'weak' or lacking in resilience. Leaders must serve as exemplars, first by acknowledging the problem in their own lives and talking about it openly. To facilitate deeper and more meaningful conversations, we developed a list of questions that we think would be useful for these conversations (Appendix B).

However, a shift towards a brighter, more positive future of medicine cannot be accomplished by a single CEO or hospital leader. The changes necessary will only be sustained with designated positions to carry out work related to burnout prevention and well-being promotion.

### **Rise of Chief Wellness Officers**

In the last five years or so, and especially during the parallel pandemic, there has been a resounding call for Chief Wellness Officers (CWOs). Nationwide demands for system-wide interventions to address physician well-being led some healthcare institutions to appoint a CWO. Incorporating CWOs into the institutional structure, these healthcare institutions were outfitted to detect and focus on healthcare workers' needs throughout the pandemic (Brower et al., 2021).

In terms of responsibilities, the CWO and their team (some working alongside or within a human resource department) would create and maintain a positive institution-wide culture of well-being by working with individuals at every institution level of the healthcare system. Kishore and colleagues (2018) state, "at all times, the CWO's function must extend beyond raising awareness to have the responsibility of improving the health and well-being of clinicians. A key role in cultivating a culture of well-being that benefits everyone, including patients."

Identifying the prevalent issue within the system and creating a position to address this issue is a step in the right direction for most healthcare institutions whose physicians are suffering. Ideally, with the proper resources and personnel, the office of the CWO will make physicians and the rest of the health care team feel as though their cries are being heard, and their hardships will be addressed.

The purpose of mentioning the rise of the CWO is not to say this is the sole solution, and it is an aspect of the solution. In addition to the addition of CWOs, there must be action at the local level. It cannot only be a top-down approach; it must be attacked from all angles.

### **Identifying Change Advocates**

As previously stated, the message of positive psychology as a method of preventing burnout cannot simply rest on the shoulders of CEOs or CWOs; there must also be local action.

Therefore, we urge healthcare institutions to identify *change advocates* within each department. These change advocates will serve as grassroots advocates for the vision. They are passionate about the initiative and will bring the lessons learned to their teams daily. Although every member of the hospital needs to understand the HEAL model and its purpose, the change advocates will be the ones to sustain it; they remind their teams to be hopeful when they lose a patient or to practice mindfulness in the face of stressful situations. In addition, they show compassion for those who are suffering from burnout and can be a trustful ear to speak to, and they can help remind physicians why they fell in love with medicine in the first place.

They hold the power of the local change in their hands, and these individuals want to be a part of the change. So, when asked, “how do you select who will be the culture champion for a particular department?” The answer would be to ask for volunteers who feel moved by this initiative and believe in its importance. Even better if institutions, led by CWOs, can compensate these local advocates for their time and efforts on well-being-related initiatives. Our advocates must not burn out in their efforts to address others' burnout and well-being for others. Thus, positive psychology principles ought to be at the center of their work, and if possible, they must be compensated appropriately.

Lead is a crucial part of the HEAL model; it symbolizes the new growth that a flourishing tree provides. It is the shade that outstretched branches offers. In order for leaders to be effective healers, they must have the tools, training and information provided by the HEAL model.

Leaders who believe in the teachings of positive psychology are needed and necessary.

### **Suggested Interventions:**

In order to promote *leadership* in physicians, we suggest the following techniques that can be undertaken by a healthcare system:

- Establish or Hire a Chief Wellness Officer for Physicians
  - Intervention: As emphasized above, we believe that every healthcare institution would benefit from having a CWO on faculty. Although having a CWO as a part of the organization is a good start, Egner, (2020) notes that there are boundaries of the organizational CWO's, and effectiveness may be compromised if the organization is too large. We urge institutions to hire CWO's for the organization in addition to local-level CWO's to reach all edges of the organization (in this case, physicians). Further, hiring a CWO supports the idea that well-being is of equivalent significance to that of financial or academic success of the organization (Berg, 2020).
  - Anticipated Outcome: The burnout crisis would not have to be addressed by those who are already burned out, the responsibility will be shifted to those who are trained, recognized, given the time and resources, and compensated, to address the issue.
- Elect Change Advocates
  - Intervention: We suggest identifying individuals within the healthcare institution to serve as change advocates within every department. To qualify for the role of change advocate, the individual must be a peer of the group with which they work and must be eager and humble to learn, listen, advocate, and enact change. These change advocates will uphold accountability standards, provide regular opportunities for education, and create opportunities for community-building and supporting one another while sharing best practices. Change advocates are the

ones who help bring mindfulness practices, character strengths initiatives and AI/ to fruition within the institution.

- Anticipated Outcome: By identifying change advocates within a department, it not only empowers the individual to feel as though their team believes in them but helps recognize natural leaders who are identified by their peers and would personally like this role.

### **Future Thinking**

The HEAL framework has been designed with physicians and healthcare organizations in mind. However, the framework can be applied to non-medical fields in which burnout is prevalent. Burnout is not physician or medicine specific. A study by Indeed.com (Threlkeld, 2021) reported that employee burnout has only gotten worse as a result of COVID-19: the organization reported that more than half (52%) of those who responded to the survey reported feeling burned out, and more than two-thirds (67%) believed the feeling has worsened over the course of the pandemic. Burnout is a pandemic of its own, it is time to heal.

### **Conclusion**

HEAL is a framework for organizational change, its purpose is to help heal the burnout of our healers and can be generalized to other industries as well. First, organizations must build and foster **hope** that greater well-being is possible; they must help healthcare workers tap into optimal **engagement** in day-to-day life on the job; they must take **actionable** steps to transform cultures through strengths-based approaches and advocacy for patients; and they must equip **leaders** with skills, roles, time, and ideally money to carry the process forward. This is not a tool that is for one-time use.

Drivers of burnout are not about a lack of individual resilience, they are about the system, the environment, and the culture. Thus, the interventions to solve this problem must exist at the systemic level. Organizational change is complicated though, and oftentimes there are individuals who have long existed within the space who will be adversaries to such change, while others may believe that the problems being addressed are not “their problem.” Therefore, this framework must be carried out at every level of the institution, and it must have buy-in from those in leadership positions to help guide all individuals toward a more positive reality in medicine. Complex problems require complex solutions. Therefore, we cannot wait, we must get started.

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### Appendix A

This is a visualization of the HEAL model, as described earlier. **Hope** is the trunk, it is the base of the tree, without a strong base, the tree would be unable to survive and grow. **Engagement** symbolizes the roots bringing nutrients directly from the soil; it is the grounding component. **Action** represents by the sunlight and water that nourishes the tree; it aids in the production of blossoming greenery and sturdy branches, and without water or sunlight, the tree cannot flourish. **Lead** symbolizes the opportunities for new growth, the oxygen that the tree provides for the environment, the shade it offers.



## **Appendix B**

An expert from the Serenity Prayer:

*“God, grant me the serenity to accept the things I cannot change,  
the courage to change the things I can,  
and the wisdom to know the difference.”*

-Reinhold Niebuhr

### **Appendix C**

A series of helpful questions that may facilitate meaningful conversations and help change advocates connect with their teams.

- What was your initial drive to become a physician? How have your motivations and connection to your sense of purpose changed over time?
- What is the most fulfilling part of being a physician for you now?
- How does your current practice align with your personal values?
- In ways that you are not living by your values, how can we change that?
- What makes you feel most alive?
- Tell me about your life outside of these walls.
- What is something you are excited about right now?
- What is something you are struggling with right now?